Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Marc T Taylor

Respondent Name
Hartford Underwriters Insurance

MFDR Tracking Number
M4-06-4570-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
March 13, 2006

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I have not contracts."

Amount in Dispute: $90.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Reimbursement for your resubmitted invoice is based upon documentation and/or additional information provided."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 31, 2005	99214, 99070	$90.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.202 sets out the fee guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 45 – Charges exceed your contracted/legislated fee arrangement. The charges have been priced in accordance to a contract owned or access by a First Health Co.
   - 0 – Reimbursement for your resubmitted invoice has been considered. No additional monies are being paid at this time. Bill has been paid according to PPO contract
   - D20 – Claim/srvc missing srvc pod info.

Issues

1. Did the respondent support reduction in payment?
2. Did the requestor submit their claim within Division guidelines?

3. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.202(d) states "in all cases, reimbursement shall be the least of the: (1) MAR amount as established by this rule; (2) health care provider's usual and customary charge; or, (3) health care provider's workers' compensation negotiated and/or contracted amount that applies to the billed service(s)." In regards to 45 – "The charges have been priced in accordance to a contract owned or access by a First Health Co.", the services in dispute were reduced in part this explanation code. However, review of supplemental insurance shows the following;
    a. Hartford paid $60 for 99214 on June 29, 2005
    b. Hartford paid $15 for 99214 on December 3, 2007
    c. Hartford paid $1.94 interest on April 5, 2008

    The total amount billed for this CPT code on this date was $75.00. This amount is paid. No additional reimbursement is due.
2. Per 28 Texas Administrative Code §134.203 (b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided…" The submitted CPT code 99070 is a "bundled code". CPT coding guidelines state the following; "This code is adjunct to basic services rendered. The physician or other qualified provider reports this code to indicate supplies and materials provided over and above those usually included with an office visit or services rendered. List drugs, trays, supplies, and other materials provided when using this code. No documentation was found to support additional reimbursement is due.
3. Review of the submitted documentation finds that the office visit charge has been paid up to the amount billed. The "supplies and materials" code submitted as 99070 was not supported with documentation. No payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	August , 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.